



# Individual Time Record Form

## 2005 Mobilization Plan

Event Name:		Resource Order Number:	
Employees Name:			
Seeking Reimbursement for: (Check One Only)		Mobilized Staff	Backfill

### Total Cost of Compensation:

Eligible Cost	Regular Rate	Overtime Rate
Base Hourly Rate: (No benefits or premiums included)	\$	\$
Social Security (Hourly): ____% (If applicable)	\$	\$
Medicare (Hourly): ____%	\$	\$
LEOFF / PERS (Hourly): ____%	\$	\$
L&I Insurance (Actual Hourly Rate) Overtime is same as regular time	\$	\$
Shift Premium	\$	\$
Medical / Dental Insurance	\$	Not applicable
Total Cost of Compensation Rate	\$	\$

### Hours Worked:

Date	Start Time	End Time	Scheduled Hours Worked	Overtime Hours	Assigned Shift (A, B, C, D) Day Off
Total Hours Worked					

### Reimbursement Sought:

	Rate	Total
Scheduled Hours	\$	\$
Overtime Hours	\$	\$
Backfill Hours	\$	\$
<b>Total</b>		\$

Backfill Total is Hours x Rate, divided by 3.

**\*\*ATTACH ONE FORM PER PERSON PER EVENT TO THE AGENCY REIMBURSEMENT FOR PERSONNEL FORM\*\***

**Return Within 45 Days of the Mobilization To:**  
Emergency Mobilization Section  
PO Box 42600  
Olympia WA 98504

Questions Call:  
360-753-0498 or  
360-753-0565  
Fax: 360-570-3136

## Mobilization Form Instructions

### Individual Time Record Form

#### Form Use:

This form is to be used to show how the Total Cost of Compensation was derived and providing a record of the hours which you are seeking reimbursement for.

#### Completing Form:

- Fill in the boxes with information requested.
- Use one form per employee, per event. If employee went to event and also filled a backfill/replacement role, two forms are needed, one for each assignment.

### EXAMPLE

Eligible Cost	Regular Rate	Overtime Rate
Base Hourly Rate (No benefits or premiums included)	\$ 10.00	\$ 15.00
Social Security (Hourly): ____% (If applicable)	\$ 1.50	\$ 3.00
Medicare (Hourly): ____%	\$ 1.00	\$ 2.00
LEOFF / PERS (Hourly): ____%	\$ 3.00	\$ 4.50
L&I Insurance (Actual Hourly Rate) Overtime is same as regular time	\$ .37	\$ .37
Shift Premium (if applicable)	\$	\$
Medical / Dental Insurance	\$ 4.50	Not applicable
Total Cost of Compensation Rate	\$ 21.37	\$ 24.87

#### Hours Worked:

Date	Start Time	End Time	Scheduled Hours Worked	Overtime Hours	Assigned Shift (A, B, C, D)
7/1/05	16:00	23:00	0	5	Day Off
7/2/05	06:00	07:00	0	1	Day Off
7/2-3/05	07:00	07:00	24	0	A
7/3/05	07:00	18:00	0	11	Day Off
7/4/05	06:00	11:30	0	5.5	Day Off
Total Hours Worked			24	22.5	

#### Reimbursement Sought:

	Rate	Total
Scheduled Hours <b>24</b>	\$ 21.37	\$ 512.88
Overtime Hours <b>22.5</b>	\$ 24.87	\$ 559.56
Backfill Hours	\$	\$
Total		\$ 1,072.44

Backfill Total is Hours x Rate, divided by 3.

This is an example of a career fire jurisdiction employee who is called in to respond to a mobilization request. On 7-2 the employee starts their scheduled 24 hour shift.

Return The Completed Form Within 45 Days Of The Event.

EMERGENCY MOBILIZATION SECTION  
PO Box 42600  
OLYMPIA WA 98504